



ABHW

Association for Behavioral
Health and Wellness

*Advancing benefits and services
in mental health, substance use
and behavior change.*

BEHAVIORAL HEALTH ORGANIZATIONS' CURRENT AND FUTURE APPROACHES TO ADDRESSING THE U.S. OPIOID CRISIS

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EXECUTIVE SUMMARY

The increasing use and misuse of prescription opioids and heroin, as well as opioid dependence and overdose (the opioid crisis), is of great concern to all Association for Behavioral Health and Wellness (ABHW) member companies. This report offers insight into the actions ABHW member companies are implementing both to help treat individuals who are misusing prescription opioids and heroin and to solve the opioid crisis.

ABHW is the national voice for specialty behavioral health and wellness companies. Members of ABHW provide insurance coverage for mental health and substance use treatment to approximately 174 million people.

ABHW member companies are attuned to the role that health plans and behavioral health organizations (BHOs) can play to address the opioid crisis. In some cases, opioid dependence is noted as one of the top diagnoses among enrollees. Many individuals with opioid and other substance use disorders (SUD) fall into high-cost, frequent readmission groups who are in need of specialized attention to encourage and support recovery. All ABHW members are eager to remain at the forefront of these efforts to improve the health of their members.

Programs specific to opioid misuse and dependence exist in these BHOs, and additional efforts are in planning or pilot phases. Many activities are also focused on improving care more broadly for members with SUD. These broader initiatives are seen as essential to improve quality of all care for consumers, and member companies interviewed emphasized that these initiatives are also expected to greatly benefit individuals with opioid use disorders.

This white paper describes the broad themes that came out of the interviews with ABHW member companies, offers some examples of innovative practices, and discusses existing barriers and how to address them.

The themes in BHOs' approaches to addressing the opioid crisis include:

- Offering comprehensive care management programs tailored to high risk SUD enrollees to proactively engage them in care.
- Improving access to and quality of treatment.
- Ensuring continuity of care appropriate for a chronic disease perspective.
- Training providers in opioid misuse and SUD in the context of pain management and in evidence-based SUD practices, especially medication-assisted treatment (MAT).
- Working beyond BHOs to engage with health plans, pharmacies, and provider organizations.
- Including other approaches: population health, supporting family members, financing, information sharing.

These ABHW member companies are being thoughtful and innovative in approaching the complex issues of opioid misuse and SUD more broadly. In a time when the urgency of this problem is highlighted daily by the media and is a key policy item for the White House,¹ this leadership of BHOs is an essential element in addressing the U.S. opioid crisis.

INTRODUCTION

Opioid misuse, dependence, and overdose are significant public health problems in the United States. Opioid prescribing has markedly increased over the past decade; some opioid use is medically warranted, yet some is misused.² Non-medical prescription opioid use has slightly decreased from 2003 to 2013 (from 5.4% to 4.9% of adults 18-64), yet prescription opioid use disorders and prescription opioid-related deaths have increased over this same period.³ The number of “high-frequency users” also increased, as did the average number of days of non-medical use.³

Heroin use, addiction, and related deaths have also continued to rise. Some suggest that restricted access to pain relievers, the relative lower cost of heroin,⁴ and easier access to heroin may be contributing factors to the shift from opioid prescriptions to heroin use. In 2013, there were 169,000 new users of heroin aged 12 years and older and an estimated 681,000 people overall who used heroin in the past year.⁴ Between 2012 and 2013, heroin overdose deaths increased by 39%.⁵

The opioid crisis results in high costs. An estimated \$25 billion in 2007 (or 45% of all societal costs of opioid misuse) was spent on healthcare due to prescription opioid misuse alone,⁶ and that amount is expected to be much greater today. One study estimated the average excess annual cost for patients who misuse opioids to be \$20,546 per privately insured patient and \$15,183 per Medicaid patient.⁷ Opioid-related problems are also linked to absenteeism and lack of productivity, high personnel turnover, and risk of injury and violence.⁸

Stakeholders from the federal and state governments, local agencies, physician practices, and health insurers are actively developing and implementing policies and interventions to address the opioid epidemic. In late October 2015 the White House announced a wide range of efforts to address prescription drug abuse and heroin use, including commitments by federal, state, and local agencies such as police departments, health care provider organizations, pharmacies, sports organizations, schools, and the media.¹ These proposals go well beyond those already in place with many of these entities.

A ROLE FOR BEHAVIORAL HEALTH ORGANIZATIONS

BHOs play an important role in access to and delivery of treatment for opioid dependence.⁹ These organizations are taking an active role in the debate and are working with states, communities, and recovery organizations in order to be engaged in responses to the opioid crisis.¹⁰

BHOs operate within a broader context that includes policymakers, governments, community organizations, systems of care, providers, the recovery community, individuals with substance use disorders, and their family and friends. BHOs recognize this wide range of stakeholders and often work with these groups to improve care for their enrollees. Yet, specific areas arise in which BHOs have a particular expertise and ability to effect change.

BHO Leverage Points:

- Working with individuals
- Working with providers
- Improving access to care
- Addressing barriers to care

BHOs emphasize the need to address addiction as a chronic condition that requires a continuum of care approach. Further, BHOs use a wide range of activities to expand use of medications to treat opioid addiction, engage members in a full treatment continuum, and make use of a wider range of support services including peers, recovery coaches, and care managers trained to address the needs of people with addictions and their family members.

This white paper reports on BHO activities to address the opioid crisis, based on phone interviews with 11 ABHW member companies. A brief methodological description is in Appendix A. A brief review of the literature is in Appendix B.

WHAT ARE BEHAVIORAL HEALTH ORGANIZATIONS DOING NOW?

BHOs are actively engaged in efforts specific to opioid misuse and dependence among their members, and are continuously planning new initiatives. Many activities are seen as essential to improve quality of care for members with SUD broadly, which includes individuals with opioid use disorders. The focus areas discussed by respondents include:

- Offering comprehensive care management programs tailored to high risk SUD enrollees to proactively engage them in care.
- Improving access to and quality of treatment.
- Ensuring continuity of care appropriate for a chronic disease perspective.
- Training providers in opioid misuse and SUD in the context of pain management and in evidence-based SUD practices, especially MAT.
- Working beyond BHOs to engage with health plans, pharmacies, and provider organizations.
- Including other approaches: population health, supporting family members, financing, information sharing.

ENGAGING ENROLLEES IN SUD TREATMENT: CARE MANAGEMENT AND OTHER APPROACHES

CARE MANAGEMENT PROGRAMS

Over half of the respondents discussed the extensive care management programs that are in place for people with SUDs and that often target people with opioid use disorders as well. Even if members with opioid use disorders are not a specific target population, they often fall into other groups (e.g., members with high readmission rates) targeted for care management approaches.

Enhanced and integrated care management programs aim to provide the right motivation and education to better enable and encourage the member to engage in treatment. Several programs, for example, have trained care managers in motivational interviewing to better identify members in need of SUD treatment, engage them in willingness-to-change processes, and successfully refer to treatment.

One BHO noted that the members who rapidly cycle through high-level admissions are often difficult to reach (e.g., if homeless). The BHO has contracted with a local “on the ground” organization to find these members, develop relationships and a care plan,

Key groups for care management:

- Individuals with high SUD readmission rates
- Consumers with admissions to intensive levels of care
- Adolescents entering residential care
- People with co-occurring severe mental illness
- Homeless individuals

Elements of successful BHO SUD care management approaches:

- Use dedicated staff trained in SUD care management
- Train care managers in motivational interviewing
- Work closely with utilization review team to facilitate transitions in SUD care and quality of ongoing care
- Have a specific care manager as a single point of contact for an enrollee
- Conduct community outreach to find difficult-to-reach members
- Integrate use of peers or recovery coaches

and work with the care management team. This BHO also has “member connections” staff who go out in the community to find members (but are not trained to engage them).

Family members of people with opioid and other SUDs can also benefit from assistance from BHOs through enhanced care management programs that include services for family members. Care managers or a licensed clinician can be available by phone as a resource for family members to help evaluate treatment and MAT options, locate treatment programs, and prepare for what happens when the person returns home.

BHOs provide support to family members:

- Care managers or clinicians available by phone to offer support
- Family meetings with the member who has SUD (if consented)
- Educate and offer guidance about treatment options
- Online resources
- Overdose prevention education

USING PRESCRIPTION AND OTHER DATA TO IDENTIFY OPIOID MISUSE, OUTLIER PRESCRIBING, AND SUD TREATMENT

Only some BHOs were able to use prescription data to identify opioid misuse or questionable prescribing practices. This was possible if the pharmacy benefit was managed by the parent company or if the health plan, or state for BHOs in a Medicaid program, facilitated access to prescription data. If data are available, BHOs can build and use data-driven algorithms to enable early intervention by trying to predict members most likely to divert or misuse opioids; some have such algorithms in place. Approaches generally were comparable to those used to identify problems via state prescription drug monitoring program (PDMP) databases. Use of multiple prescribers, pharmacies, and prescription fills by members were identifiable by several BHOs. BHOs have several options for follow-up:

- Reach out to member to educate him or her about opioid use and misuse and encourage him or her to talk to his or her physician.
- Deny authorization for the new opioid fill and instead refer the member to care management to discuss alternatives including SUD treatment.
- Contact the physician with suggestions for next steps.
- Use “lock-in” programs that require members with potential opioid misuse to use only a single prescriber or pharmacy.

Data can also be used to globally review members with SUD in order to better understand patterns of screening, use of brief intervention, treatment, MAT, and detoxification; examine high utilizers; and understand specific aspects of MAT (e.g., optimal time on buprenorphine).

IMPROVING ACCESS TO AND QUALITY OF TREATMENT

ACCESS TO SUD TREATMENT

Respondents clearly felt that access to SUD treatment can and should be improved for the benefit of all members with SUD, including those with opioid dependence. They suggested a variety of approaches that could be used to expand access to and quality of care:

- Expand SUD provider networks by including licensed alcohol or drug counselors (LADC) or certified alcohol and drug counselors (CADC); accepting all Medicaid providers; increasing methadone and MAT providers
- Engage and inform members via decision support tools, websites, apps
- Train and educate BHO staff at all levels (e.g., care advocates, utilization review team, medical directors) about evidence-based approaches for SUD treatment, especially MAT
- Increase flexibility for the delivery system, no longer require inpatient or residential care/detoxification as the first step
- Make the business case for the BHO to cover levels of care not contracted under Medicaid
- Offer weekly rounds and case presentations for care management staff, serving as both supervision and education around best practices for SUD treatment
- Provide transportation to treatment
- Offer incentives to primary care providers to address SUD or offer MAT to their patients

BHOs that contract with health plans often have contractual obligations or restrictions. Medicaid in particular may limit (or encourage) access to specific levels of care; this varies by state. One BHO has piloted approaches in several states to offer certain benefits (residential, intensive outpatient) when not covered by Medicaid. By targeting people with co-occurring mental and substance use disorders and high-level inpatient or emergency room (ER) claims, they have made a business case for the BHO to support sending the members to residential care at the BHO's expense.

With the opioid crisis overdose is a great concern; naloxone is an available immediate treatment, but post-overdose follow-up is also a key area of focus. It was difficult for some BHOs to be engaged with overdose follow-up due to the distinction between medical and behavioral benefits. Nonetheless, at least one BHO has protocols in place to be notified if a member presents in the ER with an overdose but it is often difficult to obtain information in a timely manner.

Naloxone use is encouraged, but practices vary. The potential for distributing naloxone is not being maximized in ERs or in behavioral health programs, although at least one BHO is reaching out to members at high-risk in order to train family members in the use of naloxone. Another respondent stated that naloxone distribution was not being covered, since it is prescribed "in case" rather than for an individual person with a specific incident.

MEDICATION-ASSISTED TREATMENT

All BHOs acknowledged emphatically that medications to treat opioid addiction are an evidence-based practice. BHOs strongly felt that MAT was important to offer overall and that it was not a goal to encourage one medication over another.

A range of practices are used to encourage MAT:

- Include all approved addiction medications on the formulary (unless excluded by Medicaid).
- Remove prior authorization to eliminate a barrier to treatment.
- Train BHO staff about MAT as an evidence-based practice.
- Disseminate information about MAT via flyers and provider newsletters.
- Discuss MAT with providers during care management conferences and individual conversations.
- Offer provider education and training.
- Provide technical assistance and care coordination specific for MAT providers.

Nearly all respondents mentioned a shortage of MAT providers and discussed ways to increase access:

- Offer linkages among providers, to make providers aware of who in the community is offering MAT services.
- Build MAT provider networks. This could be done empirically using claims to identify where members are getting opioid treatment, and offering education and technical assistance to providers in order to encourage MAT to be understood as an evidence-based practice.
- Work with the Addiction Technology Transfer Centers (ATTCs) and others to conduct provider MAT training.
- Share evidence-based guidelines with providers, especially if the provider is deviating from standards of care. Guidelines include using medications to address cravings (rather than requesting a longer length of stay), tailoring treatment (rather than relying on a fixed length), and using American Society of Addiction Medicine (ASAM) and American Academy for Addiction Psychiatry (AAP) tools.

Methadone is still very much in demand, and some BHOs are focusing efforts on building their methadone capacity, whereas others indicated that it is less of a strategic priority at this time. BHOs are focused on standards of care for methadone as well as improving treatment adherence.

Vivitrol (injectable naltrexone) is reported to be a valuable component of the MAT options, especially for some providers (e.g., those in rural areas or with few patients appropriate for MAT). Several BHOs highlighted innovative ways to improve their members' access to Vivitrol. Two BHOs have worked with the manufacturer, one to build a network of potential injection sites and the other to offer an upfront 60-day supply to physicians to address cost barriers.

Suboxone (buprenorphine) is the focus of concerted efforts by BHOs, where it is frequently prescribed to their members. However, many also commented on provider shortages, in part due to the training required to receive a Drug Enforcement Administration (DEA) waiver to prescribe buprenorphine and regulatory limits on buprenorphine prescribers' caseloads. The regulatory limits were less of a concern and are likely to be raised by the federal government in the near future.¹¹

Among the BHOs that contract with Medicaid programs, the buprenorphine prescriber shortage is a larger issue. Medicaid pays the same medication management charge for all medications even though buprenorphine prescribing may have more intensive needs. With the ability to have a largely private insurance- or cash-based buprenorphine practice, prescribers may limit the number of Medicaid patients that they accept. It is particularly a problem for continuity of care when Medicaid patients leave detox with a buprenorphine prescription but cannot find an outpatient provider.

IMPROVING QUALITY OF CARE

Receipt of high-quality SUD treatment by members, whether in-network or out-of-network, is a key concern. Innovative approaches include:

- Centers of excellence for addiction that are accountable for their readmissions, offer a strong MAT program starting in detox, and provide a continuum of care beyond detox.
- Treatment standards and curricula at programs showing the best success among their opioid dependent members and identify best practices to train other providers.

- A protocol-driven outpatient program to reduce variation in care across providers that incorporates training and monitoring of adherence to the protocol. The program is one year, with follow-up care management for the next two years.
- Efforts to educate members about treatment options, including specific providers or facilities.

ENSURING CONTINUITY OF CARE AND A CHRONIC DISEASE FRAMEWORK

A chronic disease approach to treatment of addictions is essential, but traditionally an acute care model has been used. Ensuring a **full continuum of care** is an important goal for these BHOs; fragmentation is a significant problem for treatment engagement. Several BHOs specifically discussed working with providers to ensure a full continuum of care is available to their members. Most respondents discussed care management programs in this context, described below. Several also discussed transitions between levels of care as a key time in which people may drop out of SUD treatment, especially moving from detox. The BHOs offered specific approaches to focus on this transition.

Aspects of a continuum of care:

- A full continuum within specific provider organizations
- Enhanced treatment offerings during nights and weekends when dropout is more common
- Care management to improve engagement in treatment and continuing care
- Care management to aid in transitions
- Longer residential detoxification stays to enable treatment engagement prior to outpatient care
- “Bridging visits” and support by care managers or recovery navigators
- Not fully detox prior to MAT induction

Recovery support (e.g., the use of peers, recovery coaches, and similar approaches) was an essential component for supporting both the treatment engagement and the long-term success of their members with SUDs. Examples include:

- A proposed peer support network to support members longer-term.
- Having peers meet with members in ERs, detox, and early recovery to reduce relapse and return to high levels of care.
- A “warm line” run by peers to offer support to members with opioid addiction.
- Recovery specialists and recovery houses as adjuncts to formal treatment.
- Collaboration and consultation with community organizations that provide peer support.
- Peer support for members with chronic pain and comorbid MH/SUD.

TRAINING PROVIDERS AND ENCOURAGING BEST PRACTICES

An area of particular attention for health plans trying to address the opioid crisis is working with providers around pain management and responsible prescribing of opioids. The ability to use this approach depends on the BHO and its relationship with the health plan or the state.

To encourage best practices around prescribing, one BHO removed prior authorization requirements for Food and Drug Administration (FDA)-approved abuse-deterrent opioid formulations and has limited prescribing of short-term opioids. If use of short-term opioids is requested beyond two fills in two months, the BHO requires that the physician and patient must have documented discussion of the risk of adverse effects including addiction and must sign an opioid medication contract.

Provider education and support for opioid prescribing is a key aspect for many BHOs. Many respondents expressed concern that providers do not understand how to treat patients who are using or misusing opioids and felt that providers would benefit from decision support tools around opioid prescribing and opioid misuse.

BHOs can educate providers:

- Chronic disease approach to SUD treatment
- Evidence-based practices for SUD treatment
- Pain management in the context of addiction
- Alternatives to opioid use for pain management
- Decision-support tools around opioid misuse

Ways to educate and support providers around best practices:

- Collaborative education program that includes PCPs and behavioral health experts
- Expert summits for provider education
- Continuing medical education credits for courses available through BHO
- Provider direct resource line for provider access to care management team

WORKING BEYOND BEHAVIORAL HEALTH ORGANIZATIONS

Many BHOs are active in the policy world – national, state, and local – and in working with recovery and other organizations. Such activities include serving on state drug utilization boards, state advisory boards and policy groups; collaborating with state PDMPs; and working with regional task forces, county authorities, and the Substance Abuse and Mental Health Services Administration (SAMHSA). BHOs also work with local and national organizations to provide services for their members (e.g., housing, community sober support systems, recovery support projects, and wraparound service organizations). Other policy work is done with organizational partners including ABHW, ASAM, Faces & Voices of Recovery and Mental Health America.

BARRIERS STOP BEHAVIORAL HEALTH ORGANIZATIONS FROM DOING MORE ABOUT THE OPIOID CRISIS – WHAT ARE THEY AND HOW MIGHT THEY BE ADDRESSED?

A number of barriers were identified by respondents that made it difficult or even precluded them from doing more to address the opioid crisis. Some barriers are unique to specific types of BHOs (e.g., not associated with a health plan, or have Medicaid contracts), but most apply broadly to all. Privacy regulations were key. Other issues included provider knowledge, interest, and availability; contractual requirements; and state regulations.

PRIVACY REGULATIONS

Privacy regulations around SUD – primarily 42 CFR Part 2 and the Health Insurance Portability and Accountability Act (HIPAA) – were by far the biggest concerns with broad-reaching implications cited by nearly all respondents. The laws and regulations create a challenge for BHOs to share information with providers (e.g., reporting prior treatment history, identifying patients with high opioid use) or with the member's support system, such as family members or recovery coaches. They limit communication among providers, and in some cases, the ability to use existing medical information to identify members at risk for opioid misuse or diversion. 42 CFR Part 2 is also a reported barrier to creating fully integrated medical and behavioral information systems, although at least one plan has done this. Data exchange is a key for improving care, but BHOs often cannot fully participate.

BHOs do recognize the real issue of protecting privacy and civil liberties and note how difficult it is to balance communication and the safety of SUD information about a person.

CONTRACTUAL OBLIGATIONS AND STATE REGULATIONS

This concern was particularly noted by BHOs with Medicaid contracts. Medicaid markets have numerous challenges. For instance, states may not allow methadone, outpatient opioid detox, some MAT, or pay for peer services. Program requirements such as who can or must receive care management vary by state. Even resource sharing for members can be more difficult when some states require use of their own websites; this makes it harder for the BHO to deliver consistent information and resources.

Suggestions for provider communication in the context of privacy regulations:

- Prescribing provider can proactively obtain patient consent that allows him or her to contact the patient's other providers (e.g., PCP, psychiatrist); this helps if the provider prescribing pain medication is worried about SUD or opioid misuse or diversion
- Standard use of consent to allow behavioral and medical sections of health plan to share information with each other

PROVIDER KNOWLEDGE, INTEREST, AND AVAILABILITY

The shortage of providers is a great barrier. Some providers will not offer MAT, some are not interested, and some lack knowledge. It is hard to engage providers around SUD broadly and MAT more specifically, and more difficult to do so in a timely manner when members need care. Further, providers' ideological beliefs (e.g., an abstinence-based model that discourages medications) may play a role in discouraging MAT, despite the evidence base.

BHOs have a role to play in getting the message out about the benefits of MAT. BHOs could help to increase access to MAT by:

- Offering linkages among providers to make providers aware of who in the community is offering MAT services.
- Building MAT provider networks. This could be done empirically using claims to identify where members are getting opioid treatment, and offering education and technical assistance to encourage MAT to be understood as an evidence-based practice.
- Considering incentives for primary care providers (PCPs) to take care of their own opioid dependent members, with MAT as an essential tool to do so.
- Working with the ATTCs and other organizations to conduct provider MAT training.
- Sharing evidence-based guidelines with providers, especially if the provider is deviating from standards of care. Guidelines include using medications to address cravings, tailoring treatment services and time, and using ASAM and AAAP tools.

Regulations regarding prescribing of opioids as well as the prescribing of buprenorphine may be a burden on providers and may limit access. New regulations on how opioids may be prescribed have led many physicians to stop prescribing, raising ethical issues for providers with patients who legitimately have pain.

OTHER BARRIERS

Siloed systems are often seen for medical versus behavioral health services and benefits, and even for mental health and SUD. Mental health and SUD treatment systems, licensure, and funding are still frequently separate in many states. This makes it difficult to provide whole person care. Other systems, such as corrections, are also important to wholly address the issues of members with SUD.

Care fragmentation is common, with many providers that do not offer a continuum of care, even within SUD treatment.

Peer providers are increasingly viewed as a key part of comprehensive support for SUD treatment, but there are concerns. These include variable training, lack of regulation, lack of reimbursement by Medicaid, and variability in each of these across states.

Competing priorities and financial constraints are common. Health care is very complex and facilitating high quality and efficient care is challenging. PCPs and other providers are highly stressed with little time to provide good care; thus they are often reluctant to take on SUD treatment, especially for opioids. Health plans and treatment programs operate under financial constraints. Even pilot efforts to improve care must demonstrate financial viability as well as being successful and well-received.

Acute treatment for a chronic disease is still usual practice. The chronic disease model is currently the best approach for treating addiction; unfortunately, it is generally not yet applied in practice. Both the delivery system and payment approaches need to reflect this chronic care model.

Reaching out to individuals in need can be a challenge. Members may not respond to phone calls or may leave before the care manager reaches them. This is particularly a concern if the member entered detox where there is no prior authorization, so the BHO may not know the person entered detox until after discharge.

WHERE DO WE GO FROM HERE?

In the course of these conversations, BHOs noted several ways in which progress can be made.

BHOs can learn from each other. This can be as simple as sharing activities about successful initiatives, as this document aims to do. It would also help if there were an easier way to obtain and share information regarding opioid misuse, MAT, etc., such as a one-stop access to summary pages hosted by a legitimate non-biased site (e.g., ASAM) or a comprehensive database and identify ways for health plans to create and disseminate information about best practices, which any plan could access.

Broader recovery support is still needed, such as patient consults offered to people who are in detox, to describe MAT and other treatment options, as well as guidance regarding which medication to use, and a list of providers. Similarly, there is a long way to go for provider education, as described above. An evidence-base exists for SUD treatment, and it should be better disseminated to improve the quality of care for people with opioid addiction and other SUDs.

The chronic care approach is now commonly accepted for people with SUDs, but the delivery and payment systems are not there. Initiatives should be developed to incentivize the continuum of care rather than an acute care approach to treatment.

Despite the evidence-base for many aspects of SUD treatment, there is not a uniform understanding of how to measure what makes high-quality SUD treatment. Several respondents mentioned the need for more objectivity regarding SUD data, standards, and measures. It was suggested that ASAM and the American Psychiatric Association (APA), for example, could be at the forefront of provider quality issues and lead metric development.

BHOs have been highly active in addressing the opioid crisis. They are one of many stakeholders that should be – and are – working together to improve the health of people in the U.S., in the context of the opioid crisis, and as other concerns arise. BHOs serve a purpose as experts, collaborators, drivers of the conversation, and providers of solutions.

APPENDIX A: METHODS

The information reflected in this white paper stems from two activities: a literature review and a summary of telephone interviews with 11 ABHW member companies.

ABHW MEMBERS 2015

Aetna Behavioral Health	Cigna	New Directions Behavioral Health
Anthem	Healthfirst	Optum
Beacon Health Options	Humana Behavioral Health	PerformCare
Cenpatico	MHN	

Each company is or includes a BHO that manages behavioral health services and provider networks for its own members or those of health plans with which the BHO contracts. These 11 companies operate in both the private and public sectors. The companies run from national to regional to single-state or sub-state coverage. Most respondents were medical directors at the BHO level, often joined by others on their team. For plans that included medical, the respondent represented behavioral health.

In the **phone interviews**, respondents were asked several major questions:

- What is your company doing regarding opioid misuse, dependence and overdose, including prevention and treatment?
- Is your company interacting with the community, states, or outside organizations about opioid misuse?
- Are there roadblocks that slow you down from giving attention to this issue? How could policymakers or organizations such as ABHW help?

We note that respondents made a clear distinction between commercial and governmental (primarily Medicaid) books of business. For commercial business, activities occurred at the BHO level and are consistent across locations, with the exception of pilot programs. For Medicaid business, state policies are a key driver for what can and cannot be implemented by the plan. This affects everything from treatment offered (e.g. methadone or buprenorphine) to care management (e.g. who can or must access care managers) to how information is provided (e.g. whether website design by the BHO or the state).

Literature review: We reviewed peer-reviewed literature as well as the gray literature (e.g., government, academic, or policy organizations) as noted below.

Peer-Reviewed Literature. PubMed and Google Scholar were searched from 2008-2015 for articles published in English related to opioid dependence, treatment protocols, best practices, and opioid prevention efforts. The search was largely limited to meta-analyses, systematic reviews, and other evidence reviews.

Gray Literature. Government websites included: Centers for Disease Control and Prevention (CDC); Centers for Medicaid and Medicare Services (CMS); Department of Justice (DOJ); FDA; National Institute on Drug Abuse (NIDA); Office of National Drug Control Policy (ONDCP); and SAMHSA. Other sources included: Alcohol & Drug Abuse Institute at University of Washington; American Association for the Treatment of Opioid Dependence (AATOD); ASAM; Institute for Clinical and Economic Review; and the PDMP Training and Technical Assistance Center/Center of Excellence at Brandeis University.

APPENDIX B: BRIEF REVIEW OF THE LITERATURE

Opioid misuse, dependence, and overdose are significant public health problems in the United States. Opioid prescribing has markedly increased over the past decade; while some opioid use is medically warranted, some is misused.² Sales of prescription opioids to treat pain (e.g., hydrocodone, morphine) quadrupled from 1999 to 2010, and opioid overdose deaths tripled from 1999 to 2012.¹² During 2011-2012, 7% of American adults aged 20 and older reported using a prescribed opioid medication in the past 30 days, of which 37% used an opioid stronger than morphine.¹²

A recently released analysis of adults in a household survey indicates that non-medical prescription opioid use has slightly decreased from 2003-2013 (from 5.4% to 4.9% of adults 18-64), yet prescription opioid use disorders and prescription opioid-related deaths have increased over this same period.³ The number of “high-frequency users”, taking opioids more than 200 days per year, also increased, as did the mean numbers of days of non-medical use of prescription opioids.³

Heroin use, addiction and related deaths have also increased and continue to rise. Some suggest that restricted access to pain relievers, the relative lower cost of heroin,⁴ and easier access to heroin may be contributing factors to the shift from opioid prescriptions to heroin use. In 2013, household survey data show 169,000 new users of heroin aged 12 years and older and an estimated 681,000 people overall who used heroin in the past year.⁴ Between 2012 and 2013, heroin overdose deaths increased by 39%.⁵

The opioid crisis also results in high costs. An estimated \$25 billion in 2007 (or 45% of the total societal costs of opioid misuse) was spent on healthcare due to prescription opioid misuse alone,⁶ and that amount is expected to be much greater today. A study in Florida estimated the average excess annual cost for patients who misuse opioids to be \$20,546 per privately insured patient and \$15,183 per Medicaid patient.⁷ Beyond healthcare utilization, opioid-related problems are linked to absenteeism, lack of productivity, high personnel turnover, and risk of injury and violence.⁸

PREVENTION OF OPIOID MISUSE, DEPENDENCE, AND OVERDOSE

Federal, state, and local governments; payers; and advocacy groups are collectively engaged in solving the opioid crisis. The 2015 U.S. Department of Health and Human Services (HHS) recommendations for prevention of opioid misuse and opioid use disorders focus on three priority areas: (1) training and educational resources to assist physicians with clinical decision making, (2) increased use of naloxone, and (3) expanded use of MAT.¹³ These recommendations build on an earlier policy that highlighted provider education, tracking and monitoring, proper disposal, and enforcement efforts to address prescription drug abuse.¹⁴ The FDA is focused on developing abuse-deterrent formulations, improving opioid labeling, educating prescribers on opioid use, and encouraging development of new products to treat opioid abuse and overdose.¹⁵ Other prevention strategies are being discussed and implemented: prescriber education on long-term opioid therapy and associated risks, use of state PDMPs, drug take-back programs and safe disposal, controlled substance lock-in programs, naloxone distribution, screening and monitoring opioid patients, and opioid dose limitation and/or tapering.^{16,17} The recent White House announcement emphasizes prescriber training and improving access to treatment.¹

TREATMENT PROTOCOLS FOR OPIOID USE DISORDER AND OPIOID OVERDOSE

The literature suggests that using behavioral and pharmacologic therapies concurrently is most efficacious for treatment of opioid use disorders. Medication-assisted treatment is clinically and cost-effective for reducing opioid misuse, overdose, and deaths, as well as improving treatment retention.¹⁸⁻²³ For opioid overdose, naloxone is a safe and effective method now widely available.

BEHAVIORAL THERAPIES, INCLUDING INDIVIDUAL AND GROUP COUNSELING

NIDA's Principles of Drug Addiction Treatment cites behavioral therapies as effective drug addiction treatments that engage individuals in treatment and provide encouragement to modify drug-seeking behaviors.²⁴ A Cochrane Review, which synthesized the findings of 11 randomized controlled studies representing nearly 1,600 adults, shows that psychosocial treatment in addition to MAT is effective in improving opioid detoxification among heroin-dependent individuals.²⁵ Improved patient outcomes included reduction in opiate use, abstinence, fewer missed treatment sessions, and increased treatment completion.²⁵

MEDICATION-ASSISTED TREATMENT (MAT)

MAT has proven to be a clinically and cost-effective intervention for individuals with opioid use disorder,^{26,27} including youth, people living with HIV/ AIDS, and pregnant women.²⁸ MAT reduces illicit opioid use and improves treatment retention,¹⁸ and is one way to expand access to SUD treatment.^{9,29} Currently, MAT includes three FDA-approved medications -- methadone, buprenorphine (Suboxone), and naltrexone (Revia, Vivitrol).^{30,31} Some literature suggests that MAT is more effective in combination with behavioral therapies.³² In 2015, ASAM released its *National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use*, which recommends MAT as an effective approach to treat opioid addiction and provides specific guidelines to assist with clinical decision-making.²⁸

EMERGENCY PROTOCOLS

Although currently limited by law in some states, naloxone (Narcan) has historically been used as a safe and effective method for opioid overdose reversal.³³ Access to naloxone is supported by numerous entities and is one of SAMHSA's strategies to prevent overdose deaths.³⁴ As of July 2015, 37 states have naloxone access laws, 24 states provide immunity to prescribers and dispensers from criminal prosecution, and 24 states authorize naloxone prescriptions by standing order.³⁵ Naloxone dispensers can include non-medical personnel such as police, family members, and bystanders. New approaches include take-home naloxone programs, which are covered by Medicaid in some states.³⁶

BEST PRACTICES FOR RESPONSIBLE OPIOID PRESCRIBING AND PAIN MANAGEMENT

A variety of best practices have been noted for responsible opioid prescribing and pain management, which include use of:

- Screening tools to assess and document medical necessity for opioid prescribing and aberrant drug-related behaviors.³⁷
- Addiction risk assessment tools.³⁸
- Patient monitoring for those who receive over 100 mg morphine equivalents (MME) of opioid medication daily and providing overall ongoing patient assessments.³⁷
- Urine drug testing to monitor opioid use.³⁷
- Patient-provider contracts for prescription opioid use.³⁷
- Prior authorization requirements for opioid prescriptions (excluding patients with cancer and terminally ill patients).³⁸
- ID requirement when picking up an opioid or other controlled medication.³⁹

All but one state currently have operational PDMPs, a state-run electronic database of information on prescribed controlled substance medications that allows providers to view their patients' prescription histories prior to prescribing.⁴⁰ Evidence suggests that PDMPs have great potential in curbing prescription opioid misuse or dependence by identifying high-risk patients, decreasing "doctor- and pharmacy-shopping" behavior, affecting opioid prescribing practices, and decreasing opioid-related overdose

deaths.^{5,41-48} Best practices that may arise from use of PDMPs or similar tracking of prescription data include:

- Prescriber alerts for patients who receive prescriptions from multiple prescribers or multiple pharmacies.^{37,38}
- Lock-in programs that require patients to obtain opioid prescriptions from only one provider and/or one pharmacy.³⁹

Opioid prescribing guidelines are another tool which can be effective in reducing prescribed dosage of long-acting opioids, the number of patients who receive opioids, and opioid-related overdose deaths.⁴⁹ Guidelines may include recommendations for the lowest effective opioid dose and tapering protocols³⁷ and treatment plans that use alternative, non-opioid options such as other types of medications (e.g., muscle relaxants, NSAIDs), acupuncture, physical therapy, etc.³⁸

Overdose education and naloxone programs, which utilize naloxone to reverse opioid and heroin overdoses, are proven to reduce opioid-related deaths.⁵⁰ As of July 2015, 40 states and Washington, DC, allow full or restricted use of naloxone.⁵¹ The use of Good Samaritan laws in regards to naloxone use is a best practice for states.³⁹

Health plans have also contributed to addressing the opioid problem.⁵² Strategies include collaborating with community partners, using individualized treatment plans, encouraging providers to use evidence-based prescribing practices, and in some cases, modifying health plan benefits to promote use of safer opioid prescriptions.⁵³ In the medical community, 27 physician organizations and seven state medical societies, including the American Medical Association (AMA), American Academy of Family Physicians, AAAP and many others, organized a *Task Force to Reduce Opioid Abuse* by focusing on five goals: (1) physicians' PDMP registration and use, (2) physician education on evidence-based prescribing, (3) reduction of stigma related to pain and promotion of comprehensive assessment and treatment, (4) reduction of stigma related to SUD and increased access to treatment, and (5) expansion of naloxone use.⁵⁴

APPENDIX C: DETAILED EXAMPLES OF SELECTED BEST PRACTICES

Comprehensive care management program: A targeted enhanced care management program for SUD was described in detail by one BHO; others reported similar approaches. It builds on existing enhanced care management models for members with mental disorders or co-occurring MH/SUD. The BHO targets members with high 60-day readmission rates as well as members with Level IV admissions; women who are pregnant with an inpatient MH/SUD admission (SUD primary); adolescents entering rehab; members with co-occurring severe mental illness and SUD; and those dually eligible for Medicare and Medicaid. Certified addiction counselors are used as SUD care managers, and individuals trained in SUD review authorization requests. The care manager has a wide-ranging approach:

- While the member is inpatient, review treatment history, current status, prior outcomes, success, and barriers.
- Coordinate with current provider, discuss recommendations, encourage a full continuum of care, and work with provider to develop a care plan in a timely manner.
- Review discharge plan to ensure that medications are on the formulary and confirm that the member can access MAT once outpatient (e.g., providers are available).
- Participate in treatment team meetings, use motivational interviewing with the member, and counsel “natural supports” or others invited by the individual (after consent is obtained).

- Follow the member post-discharge to support engagement in the next level of care. If discharged to the community, help with appointment reminders and treatment linkages.
- Develop a communication plan with the member to help keep them engaged for at least three months.

Integrated SUD treatment and pain management: One BHO offered an example of a SUD treatment provider that integrates pain management. It allows a longer titration time for opioid detox and incorporates MAT induction. Alternatives to opioids to treat pain are offered (e.g., physical therapy, acupuncture) and encouraged, and a multidisciplinary team is involved. Behavioral and medical information are shared with the care manager as well as the prescriber in the community (with consent obtained as part of the program).

Support family members: Family members of people with opioid and other SUDs can also benefit from assistance from BHOs through enhanced care management programs that include services for family members. For instance, care managers can support family members by engaging them in active conversations regarding care plan development and implementation, connecting with the member in need if consented, and supporting the family member’s own needs at the same time. A pilot family support program offers a licensed clinician available by phone as a resource for family members to help evaluate treatment and MAT options, locate treatment programs, and prepare for what happens when the person returns home. Another BHO offers “in the moment coaching” to family members who are seeking treatment information, to assist with talking points and other needs even if the coach cannot disclose information about the consumer without consent. Such an approach allows the family member to obtain help without breaching confidentiality. Online resources also can be targeted to family and others. As noted above, family members also may be engaged to prevent overdose via use of naloxone.

Consider the health of the population more broadly: Several respondents suggested that a role they could play in addressing the opioid crisis is to take a population health perspective. That is, they can identify trends in opioid misuse, overdoses, dependence, and SUD overall in their member populations or their communities. BHOs have many covered lives and an immense amount of data; they can conduct analyses to track trends in opioid misuse, dependence, and overdose. This information could be used directly by the BHO as it considers ways to address those trends and also could be shared with the state or the community that the data reflect. At least one BHO views its communities, not just its members, as a focus for improved health more broadly.

One BHO, for example, is evaluating spikes in heroin use and overdose deaths in one state. Another is monitoring increases in heroin use using public data and market information and then linking this to its own data. Similar approaches have indicated a pent-up demand for opioid treatment, especially in states with Medicaid expansion.

Innovations: Along the lines of innovation are a variety of approaches. Two respondents mentioned recovery apps for smartphones. One BHO is developing provider tiering with premier designations that are based on readmission rates. Another is considering contingency management for people with opioid use disorders who are treated in outpatient clinics. Two respondents mentioned being able to support “disruptive innovators” such as the police chief in Gloucester, Massachusetts, who is offering assistance to anyone who wants to access SUD treatment, without facing criminal penalties.

Financing and incentives: These offer a way to improve treatment approaches. One BHO is considering creative contracting, such as paying for a period of time with as much care as is needed to engage a member in treatment. Another is using value-based purchasing for SUD providers and incentivizing them to engage their patients in the step-down level of care. By moving towards a case rate approach, especially for providers who offer a continuum of care, this BHO notes that it gets out of the middle of a treatment episode. Preferential cost-sharing can be used to encourage member use of providers that are recognized as centers of excellence, and incentives can be used to encourage PCPs to take care of their own opioid dependent members. Bundled payments might help with MAT provided by a PCP. Similarly, alternative payment mechanisms can align financing with the chronic nature of addiction.

APPENDIX D: REFERENCES

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